



Life Insurance Benefits Application Instructions

Standard Insurance Company, Life Benefits Department
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

PLEASE READ CAREFULLY

The application for life insurance benefits consists of the forms included in this packet as well as the additional information noted under item 1 below. Please fill out every space on the Proof of Death form to avoid delays in our examination of your application for benefits. If a section does not apply, or information is not available, please write "NONE" in the space, so that we know you did not overlook the particular question. **If an incomplete form is received, it may be returned for completion.**

1. Include the following information with the Proof of Death form.

- Beneficiary Statement(s).
(See attached. If there are more than two beneficiaries, please make a copy of the front and back of the statement.)
- Certified death certificate.
- All original enrollment forms and change of beneficiary cards.
- For AD&D and Seat Belt claims, attach newspaper clippings, police or accident reports, and any other information available regarding the accident.

2. Please have the beneficiary(ies) carefully read and complete the Beneficiary Statement which contains information about taxes and the Standard Secure Access account.

Beneficiaries of \$10,000 or more will receive the funds via Standard Secure Access (SSA). SSA is a convenient, interest-bearing checking account in which life insurance proceeds are deposited. With SSA, the beneficiary is able to earn a competitive rate of interest on the life insurance proceeds while taking the time to weigh important financial decisions that often follow the death of a loved one.

The beneficiary will receive the checkbook within 2 to 3 days from the time the claim is approved via U.S. Post Office Priority Mail service. In addition, all SSA accountholders have access to 24-hour customer service via a voice response unit (VRU) and a dedicated customer service team at State Street Bank in Boston, Massachusetts. This team is staffed from 8:30 a.m. to 6:00 p.m. Eastern Standard Time.

Please make sure all required forms are completed and returned to our office. Our examination of the claim will begin when all completed forms are received. Should you have questions, our office is available to assist you. Please call **1-800-628-8600** or **(503) 321-6360** or e-mail us at **lifebenefits@standard.com**.



Life Insurance Benefits Proof of Death Claim Form

Standard Insurance Company, Life Benefits Department
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Forms may be returned for unanswered questions.

| | | | | |
|--|----------|----------------|--|----------|
| Name of Deceased: | | | Effective Date of Member's Insurance: | |
| Social Security No.: | | | Date of Membership/Employment: | |
| Date of Birth: | | | Date member last reported for work: | |
| Date of Death: | | | Reason member did not return to work: <input type="checkbox"/> Death <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain) _____ | |
| If Dependent Claim, Name of Member: | | | Last month premium was paid for member or dependent: | |
| Group Policy No.: | | | Monthly or annual salary: \$ | |
| Insurance Class (see contract): | | | Date of last salary increase: | |
| Amount of insurance claimed: Basic life \$ _____ Dependent life \$ _____ Additional life \$ _____ Other (specify) \$ _____ Accidental death \$ _____ | | | Salary prior to increase: \$ Usual number of hours employee worked per week: Amount of monthly premium paid for the insured: | |
| Member also had the following claims with Standard Insurance Company: (check all that apply) <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Waiver of Premium | | | Member was: (check all that apply) <input type="checkbox"/> Full-Time <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Part-Time <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried <input type="checkbox"/> Commissioned <input type="checkbox"/> Active <input type="checkbox"/> Retired | |
| Name of Beneficiary | Relation | Date of Birth | Address | Phone |
| | | | | |
| | | | | |
| | | | | |
| Remarks: | | | | |
| In addition to this form, the following items are required. <ul style="list-style-type: none">• Beneficiary Statement.• Original enrollment forms and any subsequent beneficiary changes.• Certified death certificate.• For AD&D and Seat Belt Claims, newspaper clippings, police and accident reports, or other information regarding the accident. | | | | |
| Acknowledgement <p>I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on the following page of this form.</p> | | | | |
| Signature of Benefit Administrator | | Date | Name of Employer or Association | |
| Benefit Administrator's Name (Please print) | | Street Address | | |
| () _____ Phone No. | | City | State | Zip Code |
| Payments of \$10,000 or more are paid via SSA and will be sent directly to beneficiary, unless requested otherwise. | | | | |



Life Insurance Benefits Claim Form Fraud Notices

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PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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ALL OTHER APPLICANTS AND CLAIMANTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.



Life Insurance Benefits Beneficiary Statement

Standard Insurance Company, Life Benefits Department
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

TAX INFORMATION

Under the Federal Income Tax law, we are required to request that you (*as the payee*) provide Standard Insurance Company (*as payor*) with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with Federal Income Tax law.

CERTIFICATION — Under Penalties Of Perjury, I Certify That:

1. The number shown on this form is my correct Social Security/Taxpayer Identification Number (*or I am waiting for a number to be issued to me*), **and**
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

CERTIFICATION INSTRUCTIONS — You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

METHOD OF PAYMENT —

Standard Secure Access

Beneficiaries of \$10,000 or more will receive the funds via Standard Secure Access (SSA). SSA is a convenient, interest-bearing checking account in which life insurance proceeds are deposited. With SSA, you are able to earn a competitive rate of interest on the life insurance proceeds while taking the time to weigh important financial decisions that often follow the death of a loved one.

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If you decide to assign a portion of your benefits to a funeral home, please include a notarized assignment form (*supplied by the funeral home*) and an itemized copy of the funeral bill. A separate check for the amount of the assignment will be delivered directly to the funeral home.

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on the following page of this form.

Signature of Beneficiary (*Please use dark ink and sign as you would a check.*)

Relationship to Deceased

Name (*Please Print*)

Date of Birth

Social Security Number (*required*)

Address

City

State

Zip Code

()

Work Phone No.

()

Home Phone No.

THIS PORTION FOR USE BY STANDARD INSURANCE COMPANY ONLY

Claim No.(s)

Policy No.(s)

Deposit Amount \$

Division 037

Sub 107

Code 402 ☐ 403 ☐ 404 ☐ 405 ☐ 406 ☐ 407 ☐

☐ M ☐ F

Transmittal Date

Authorized Signature

Policyowner

Name of Deceased:

Use Only

Group Policy No.:



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NEW JERSEY RESIDENTS

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NEW YORK RESIDENTS

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Relationship to Deceased

Name (*Please Print*)

Date of Birth

Social Security Number (*required*)

Address

City

State

Zip Code

()
Work Phone No.

()
Home Phone No.

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Claim No.(s)

Policy No.(s)

Deposit Amount \$

Division 037

Sub 107

Code 402 ☐ 403 ☐ 404 ☐ 405 ☐ 406 ☐ 407 ☐

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